

CHAPTER

13

Status report on Part D

Status report on Part D

Chapter summary

Each year the Commission provides a status report on Part D to monitor program performance by examining beneficiary access and program spending, discussed below.

Enrollment in Part D—In 2010, 90 percent of Medicare beneficiaries had Part D drug coverage or its equivalent. Nearly 60 percent were enrolled in Part D plans, slightly over 30 percent had other sources of creditable coverage, and 10 percent had no drug coverage or coverage less generous than Part D. Among those in Part D plans, about 36 percent (about 10 million) received the low-income subsidy (LIS); 600,000 of them may be reassigned to different plans because their previous plan's premium no longer falls below the 2011 LIS threshold. Some LIS enrollees choose a plan other than their random assignment. In 2010, about 1.7 million LIS members were enrolled in a plan they selected but did not qualify as premium-free. Roughly two-thirds of Part D enrollees were in stand-alone prescription drug plans (PDPs); the rest are in Medicare Advantage–Prescription Drug plans (MA–PDs). Most enrollees report high satisfaction with the Part D program and with their plan.

Benefit offerings for 2011—Sponsors are offering about 30 percent fewer PDPs than in 2010. About 15 percent fewer MA–PDs are available in 2011, reflecting a decline in private fee-for-services plans and local HMOs. The reductions are primarily the result of CMS's regulations and guidance

In this chapter

- Part D enrollees' access to prescription drug benefits in 2010
- Costs of Part D
- Measuring plan performance in Part D
- Policy issues

intended to differentiate more clearly between basic and enhanced benefit plans and to reduce the number of plans with low enrollment. These declines should not have a large impact on access, as beneficiaries will have 28 to 38 PDP options along with many MA–PDs, and more PDPs are available to LIS enrollees with no premium. For 2011, a larger share of PDPs are offering some gap coverage, while the benefit offerings for MA–PDs remain largely unchanged.

Part D spending—In 2009, Part D spending totaled \$52.5 billion, and CMS expects it will have reached \$56 billion in 2010. These expenditures cover the direct monthly subsidy that plans receive for their Part D enrollees, reinsurance for very-high-cost enrollees, premiums and cost sharing for LIS enrollees, and payments to employers that continue to provide drug coverage to retirees who are Medicare beneficiaries. In 2009, LIS payments continued to be the largest component of Part D spending. Medicare’s reinsurance payments have been the fastest growing component of Part D spending, primarily due to the difficulty in negotiating rebates for high-cost drugs and biologics that have few, or no, competing therapies.

Between 2007 and 2008, average per capita gross spending for drugs covered in Part D grew by 4.2 percent. Growth in per capita spending varied across different groups, with non-LIS enrollees experiencing lower growth (1.9 percent) than LIS enrollees (7.6 percent). Although percentage growth in per capita spending among MA–PD enrollees was greater than for PDP enrollees, the dollar increase was \$11 for both groups.

Growth in Part D premiums—For the basic portion of the benefit (which does not include premiums for enhanced benefits), CMS estimates the actual average monthly premium at \$30 for 2011, which would be an increase of \$1 over the 2010 average. The estimate reflects CMS’s expectation that some Part D enrollees will switch to plans with lower premiums. We did not calculate the expected average premiums for 2011. With many plans (30 percent of PDPs and 15 percent of MA–PDs) discontinued or consolidated in 2011, there is greater uncertainty about beneficiaries’ choice, making it difficult to calculate the average premium for 2011.

CMS’s quality measures for Part D—CMS publishes 19 performance metrics aggregated into a five-star rating system on the Medicare Prescription Drug Plan Finder at www.medicare.gov. To date, the metrics focus mostly on customer service and enrollee satisfaction. Although the metrics now include some quality measures, additional measures on patient safety and appropriate use of medication could provide further information on quality. ■

**TABLE
13-1****Parameters of the defined standard benefit increase over time**

	2006	2010	2011
Deductible	\$250.00	\$310.00	\$310.00
Initial coverage limit	2,250.00	2,830.00	2,840.00
Annual out-of-pocket spending threshold	3,600.00	4,550.00	4,550.00
Total covered drug spending at annual out-of-pocket threshold	5,100.00	6,440.00	6,447.50*
Maximum amount of cost sharing in the coverage gap	2,850.00	3,610.00	3,607.50
Minimum cost sharing above annual out-of-pocket threshold:			
Copay for generic/preferred multisource drug prescription	2.00	2.50	2.50
Copay for other prescription drugs	5.00	6.30	6.30

Note: *Total covered drug spending at annual out-of-pocket threshold depends on the mix of brand-name and generic drugs filled during the coverage gap. The amount for 2011 (\$6,447.50) is for an individual with no other sources of supplemental coverage filling only brand-name drugs during the coverage gap.

Source: CMS, Office of the Actuary.

Each year since 2006, the Commission has provided a status report on Medicare's Part D program. To monitor the ability of the program—under its competitive approach—to meet Medicare's goals of maintaining beneficiary access while holding down program spending, we examine several performance indicators: beneficiaries' access to prescription drugs (including data on enrollment and changes in Part D plan benefit designs and formularies for 2011), program costs, and quality of services.

Background

Medicare's payment system for Part D differs from its payment systems for fee-for-service providers. It uses competing private plans to deliver prescription drug benefits, and, instead of setting prices administratively, Medicare's payments to Part D plans are based on bids submitted by plan sponsors.

Part D uses two avenues of competition designed to give plan sponsors incentives to offer beneficiaries attractive prescription drug coverage while controlling growth in drug spending. First, private plans must compete for enrollees. Ideally, beneficiaries choose a plan that provides access to the medications they need at premiums and copays they are willing to pay, and they reevaluate that decision from time to time. In a second avenue of competition, sponsors may seek to gain market share by annually bidding below regional thresholds to qualify their plans to remain premium-free for most enrollees who receive Part D's low-income subsidy (LIS).

So far, each year only about 6 percent of Part D enrollees have switched plans voluntarily—a proportion similar to “switchers” in the Federal Employees Health Benefits program. Experience suggests that beneficiaries do not switch plans in large numbers for several reasons. Many beneficiaries are satisfied with their choice. In other cases, they want to avoid the difficulties involved in comparing dozens of plan benefits that differ on many dimensions, such as cost-sharing requirements, formularies, utilization management, and quality of services. These barriers to switching thwart the program's intended goal of competition. That is, if beneficiaries are unwilling to switch, even when faced with a significant premium increase, sponsors have less of an incentive to compete on premiums and control drug spending.

Medicare defines a standard Part D benefit structure with parameters that change at the same rate as the annual change in beneficiaries' average drug expenses (Table 13-1). For 2011, the defined standard benefit includes a \$310 deductible and 25 percent coinsurance until the enrollee reaches \$2,840 in total covered drug spending. Enrollees exceeding that total face a coverage gap up to an annual threshold of \$4,550 in out-of-pocket (OOP) spending that excludes cost sharing paid by most sources of supplemental coverage, such as employer-sponsored policies. Enrollees with drug spending exceeding that amount pay the greater of either \$2.50 to \$6.30 per prescription or 5 percent coinsurance.

Before 2011, enrollees exceeding the initial coverage limit were responsible for paying the full discounted price of covered drugs (usually without reflecting

Phasing out the coverage gap

Under the Patient Protection and Affordable Care Act of 2010 (PPACA), Part D's coverage gap will be phased out gradually. By 2020, the law will reduce Part D's cost sharing in the coverage gap from 100 percent to 25 percent. PPACA also temporarily slows the annual rate of growth in Part D's out-of-pocket (OOP) threshold between 2014 and 2019.¹

The law uses different approaches to reduce cost sharing in the coverage gap for brand-name drugs and generic drugs. For brand-name drugs, manufacturers that want to continue including their products in the Part D program must sign contracts with CMS to participate in the coverage gap discount program.² Beginning in 2011, manufacturers provide Part D enrollees a 50 percent discount for brand-name drugs while enrollees are in the coverage gap; that is, once enrollees reach the coverage gap, they pay 50 percent of the plan's negotiated price to the pharmacy as their cost sharing and drug manufacturers pay the remainder. Under the law, the portion paid by the manufacturers

counts toward Part D's annual OOP threshold, which will likely have the effect of increasing the share of Part D enrollees who reach the catastrophic phase of coverage.

Over time, the Part D benefit will also begin to cover more of enrollees' spending in the coverage gap. Beginning in 2013, enrollees' cost sharing for brand-name drugs will decline from 50 percent in the coverage gap (100 percent minus the manufacturers' 50 percent discount) to 47.5 percent, with the benefit covering the remaining 2.5 percent. By 2020, enrollees' cost sharing for brand-name drugs will decline to 25 percent—the same share covered in the initial coverage phase of the defined standard benefit—effectively eliminating a gap in coverage for these drugs.⁴ For generic drugs, in 2011, the Part D benefit begins covering 7 percent of the plan's negotiated price in the coverage gap, leaving the enrollees with 93 percent coinsurance. By 2020, Part D will cover 75 percent and the enrollee will be responsible for 25 percent of the cost of all drugs in the coverage gap. ■

manufacturers' rebates) up to the annual OOP threshold. Because of changes made by the Patient Protection and Affordable Care Act of 2010 (PPACA), beginning in 2011, beneficiaries face reduced cost sharing for both brand-name and generic drugs in the coverage gap (see text box). In 2011, the cost sharing for prescriptions filled during the gap phase is 50 percent for brand-name drugs and 93 percent for generic drugs. An individual with no other source of drug coverage reaches the \$4,550 limit at \$6,447.50 in total drug expenses (the enrollee's spending plus spending the Part D plan covers).³

Part D enrollees' access to prescription drug benefits in 2010

Implementation of the Part D program in 2006 increased the share of beneficiaries who have drug insurance from 75 percent before Part D to about 90 percent. In general, Medicare beneficiaries appear to have good access to

prescription drugs. All individuals have access to dozens of Part D plan options, and many continue to receive drug coverage through former employers. Surveys indicate that beneficiaries enrolled in Part D are generally satisfied with the Part D program and with their plan (Department of Health and Human Services 2010, J.D. Power and Associates 2006, Keenan 2007, PRNewswire 2010, Weems 2008).

In 2010, 90 percent of Medicare beneficiaries had drug coverage, 59 percent were in Part D plans

In 2010, 90 percent of Medicare beneficiaries had prescription drug coverage at least as generous as Part D's defined standard benefit—called creditable coverage (Figure 13-1). In February 2010, 59 percent of 46.5 million Medicare beneficiaries were enrolled in Part D plans. Slightly more than 30 percent of beneficiaries had other sources of creditable coverage, including those with employer-sponsored plans that receive Medicare's retiree drug subsidy, the Department of Veterans Affairs,

TRICARE (the Department of Defense's health benefit for retired military members), and other payers.⁵ An estimated 4.7 million Medicare beneficiaries (10 percent) had no drug coverage or coverage less generous than Part D's benefit. Research indicates that beneficiaries who do not enroll in Part D tend to have lower drug spending, better health, and lower risk scores (Heiss et al. 2006, Riley et al. 2009).

In 2010, about 10 million individuals, or 36 percent of Part D enrollees, received the LIS. Of them, 6.4 million were dually eligible to receive Medicare and Medicaid. Another 3.5 million qualified for the LIS either because they receive benefits through the Medicare Savings Program or the Supplemental Security Income program or because they were determined to be eligible by the Social Security Administration after applying directly to that agency. Among LIS beneficiaries, about 8 million are enrolled in stand-alone prescription drug plans (PDPs) and 2 million are in Medicare Advantage–Prescription Drug plans (MA–PDs).

The share of Medicare beneficiaries enrolled in Part D has grown slightly since the program began, from 55 percent in 2006 to 59 percent in 2010. Most of that growth is due to expanded enrollment in Medicare Advantage plans.

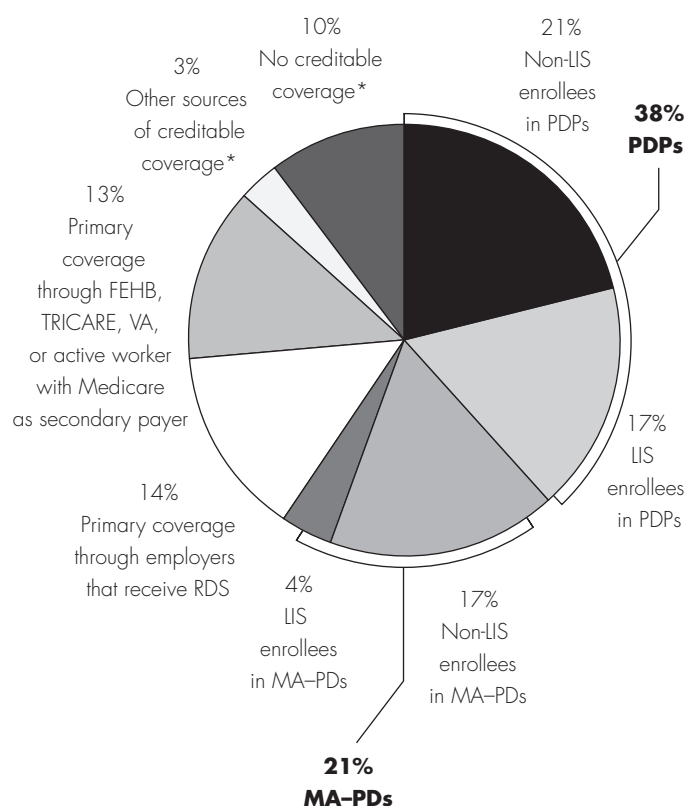
Distribution of enrollment across regions

Part D enrollment varies geographically. In each of the 34 PDP regions across the country, 2008 enrollment ranged between 40 percent and 69 percent of Medicare beneficiaries (Medicare Payment Advisory Commission 2010a). Part D enrollment tends to be lower in states with large employers that receive Medicare's retiree drug subsidy—Michigan and Ohio, for example. In parts of the West (Arizona, California, Colorado, Nevada, and New Mexico), Florida and Hawaii, and some parts of the Northeast (the Pennsylvania/West Virginia region), more than 40 percent of Part D enrollees are in MA–PDs. By comparison, in other parts of the Northeast, Midwest, and southern–central states, less than 20 percent of Part D enrollees are in MA–PDs.

In 2008, Part D enrollees were more likely to be female and minority than the overall Medicare population. Compared with PDP enrollees, beneficiaries enrolled in MA–PDs were less likely to be disabled and more likely to be Hispanic, which may reflect the underlying demographic characteristics of areas where many MA–PDs are located. LIS enrollees were more likely than

FIGURE 13–1

In 2010, 90 percent of Medicare beneficiaries were enrolled in Part D or had other sources of creditable drug coverage

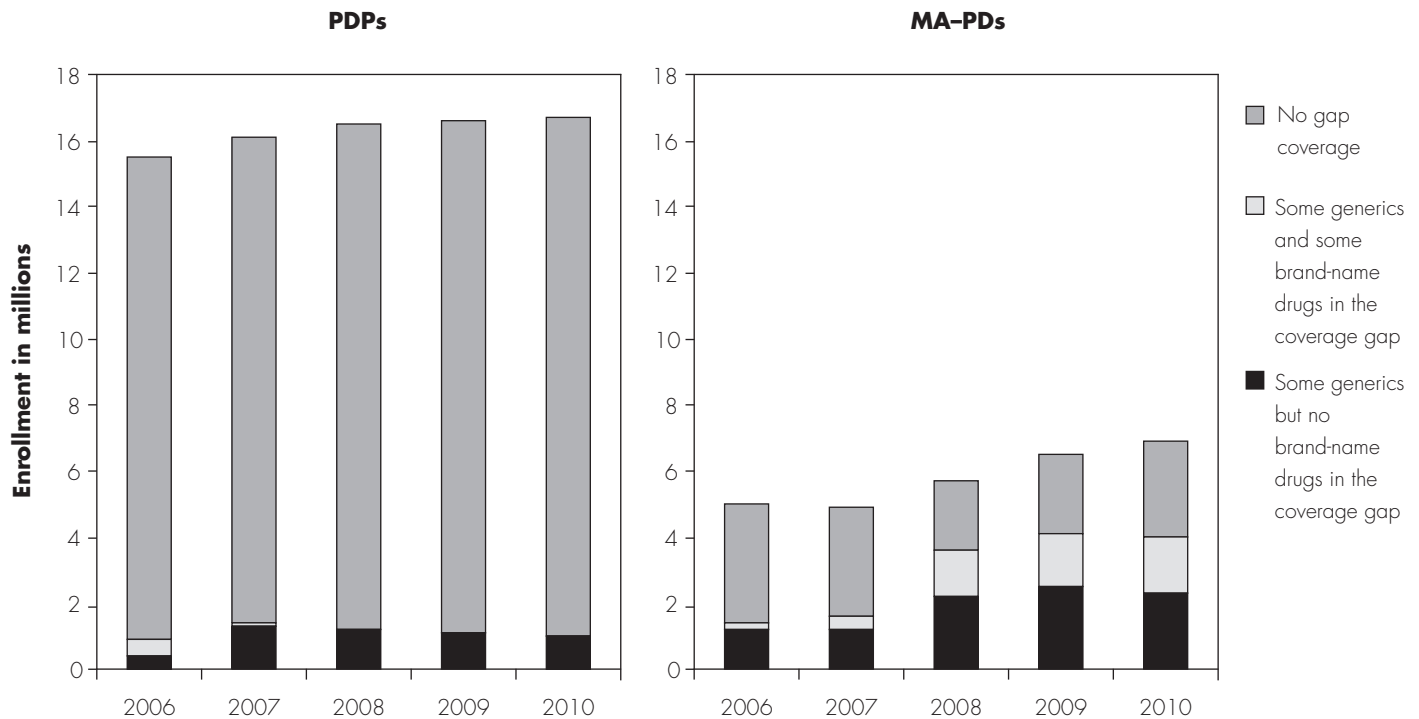


Note: LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), RDS (retiree drug subsidy), FEHB (Federal Employees Health Benefits program), VA (Department of Veterans Affairs). TRICARE is the health program for military retirees and their dependents. Components may not add to 100 percent due to rounding. *Creditable coverage means drug benefits whose value is equal to or greater than that of the basic Part D benefit.

Source: 2010 enrollment information from CMS. <http://www.cms.gov/PrescriptionDrugCovGenIn/>.

Medicare beneficiaries overall to be female, minority, and disabled beneficiaries under age 65.

The share of beneficiaries receiving Part D's LIS also varies considerably by region. In 2008, 50 percent or more of enrollees in Alaska, Louisiana, the Maine/New Hampshire region, and Mississippi received the LIS. By comparison, 30 percent or less of enrollees in the upper Midwest and several central–western states received the LIS. Participation in Part D's LIS program is related to many factors, such as underlying rates of poverty and health status in each region, the degree to

**FIGURE
13-2****PDP enrollees are less likely to have benefits in the coverage gap**

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]).

Source: MedPAC analysis of CMS landscape and enrollment data.

which a state's Medicaid program reaches out to enroll eligible individuals, and the criteria states use to determine eligibility for their programs. For example, states can increase the number of residents eligible for the Medicare Savings Program by not counting certain types of assets or sources of income in their eligibility criteria for Medicaid benefits.

Distribution of enrollment across plan types

Most Part D enrollees are in plans other than the Part D standard benefit; these plans are actuarially equivalent to the standard benefit or are enhanced in some way. Actuarially equivalent plans have the same average benefit value as defined standard plans but a different benefit structure (both actuarially equivalent and defined standard plans are referred to as basic benefits).⁶ For example, a plan may use tiered copays (e.g., charging \$7 per prescription for a generic drug and \$50 per prescription for a brand-name drug) rather than 25 percent coinsurance for all drugs. Alternatively, instead of having a deductible, a plan may use cost sharing equivalent to a rate higher than

25 percent. Once a sponsor offers at least one stand-alone PDP with basic benefits in a PDP region, it may also offer a plan with enhanced benefits—basic and supplemental benefits combined, with a higher average benefit value. Medicare does not subsidize supplemental benefits; enrollees must pay the full premium for the additional coverage.

In 2010, 68 percent of PDP enrollees had basic coverage that was actuarially equivalent to the defined standard benefit, most with tiered copays. Another 22 percent of PDP enrollees had enhanced benefits—the typical enhancement being a lower deductible rather than benefits in the coverage gap.⁷ The remaining 9 percent were in defined standard plans. MA-PD enrollees were also predominantly in plans that use copays, with 99 percent in actuarially equivalent or enhanced plans.

Enrollees in stand-alone PDPs are more likely than enrollees in MA-PDs to have a deductible in their plans' benefit design. In 2010, about half of PDP enrollees paid no deductible or a lower deductible than was prescribed

in the defined standard benefit; the remaining enrollees were in plans with the standard \$310 deductible. By comparison, 98 percent of MA–PD enrollees had a reduced deductible or no deductible. This circumstance reflects the ability of MA–PDs to use Medicare Advantage (Part C) rebate dollars to supplement benefits or lower premiums.⁸ Many MA–PDs use some of their Part C rebate dollars to enhance their Part D benefit by charging no deductible, providing benefits in the coverage gap, or reducing their premium.

The ability of MA–PDs to use Part C rebate dollars to enhance their Part D benefits affects the difference between PDPs and MA–PDs in the availability of plans that offer benefits in the coverage gap (Figure 13-2). In 2010, only 6 percent of PDP enrollees (about 1 million beneficiaries) were in plans that offered benefits in the coverage gap, usually for generic drugs. However, 45 percent of PDP enrollees received Part D’s LIS, which effectively eliminates their coverage gap. By comparison, 58 percent of MA–PD enrollees (about 4.1 million beneficiaries) were in plans that offered gap coverage. Of those enrollees, most were in plans that covered generic drugs but no brand-name drugs.

Use of Part D benefits and share of enrollees reaching the coverage gap

Prescription drugs are used widely by Medicare beneficiaries. According to the Commission’s analysis of 2008 prescription drug event data taken from Part D claims, nearly 92 percent of Part D enrollees filled at least one prescription during the year. Enrollees filled an average of 4.1 prescriptions per month, with higher average utilization among those who received the LIS (4.9 per month) than among beneficiaries who did not (3.6 per month). While LIS enrollees tend to have a greater disease burden than non-LIS enrollees, under Part D they have much lower cost sharing, ranging from no copay to about \$6 per prescription for dual-eligible beneficiaries, who have the most comprehensive benefits. Other LIS enrollees pay 15 percent coinsurance. By comparison, in 2010, median copays for non-LIS enrollees were about \$7 per generic prescription and more than \$75 per prescription for nonpreferred brand-name drugs.

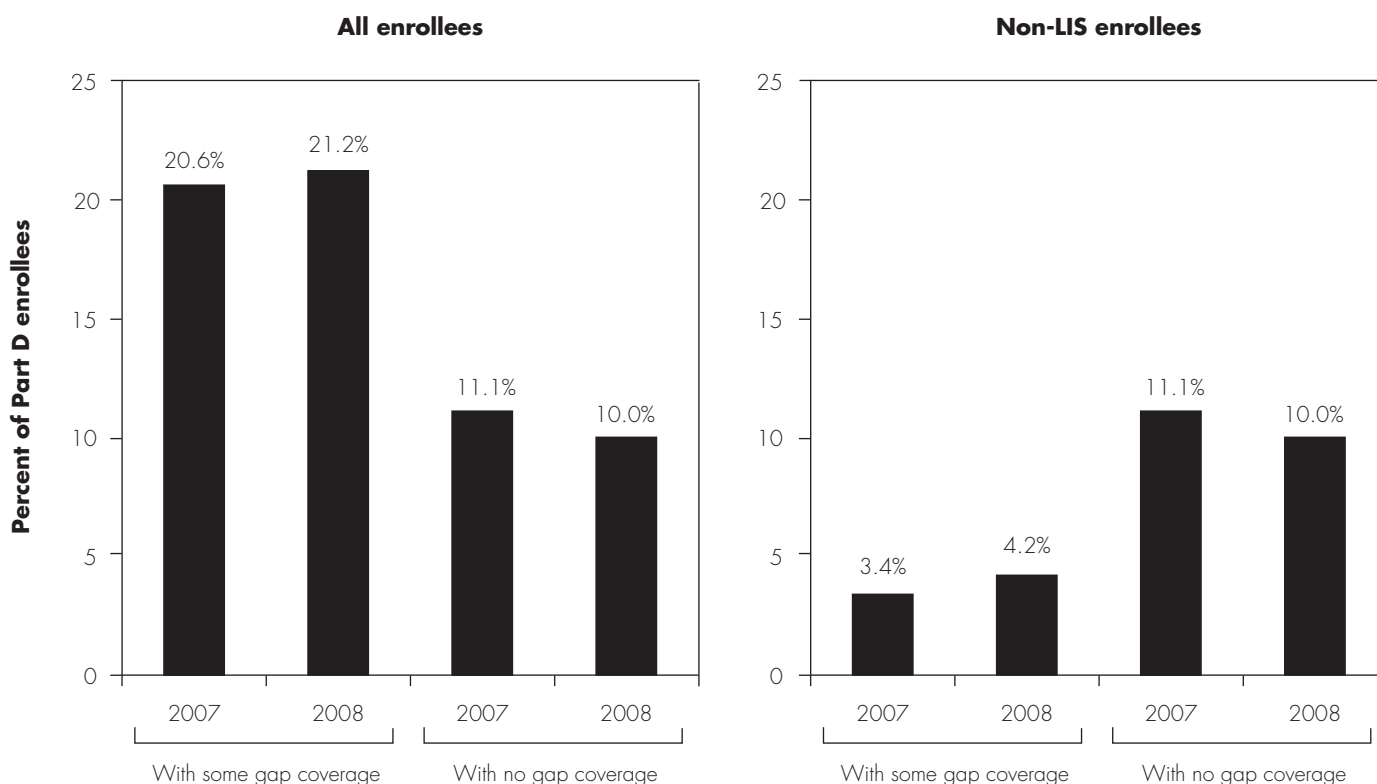
In 2008, the share of Part D enrollees with benefit spending that was high enough to put them in the coverage gap remained stable at around one-third of enrollees (Centers for Medicare & Medicaid Services 2010b). In Part D’s coverage gap, most non-LIS enrollees face 100

percent of the plan’s negotiated cost of the drug, unless they are in a plan that provides some benefits in the gap. In 2008, about 2.8 million beneficiaries (10 percent of Part D enrollees) were exposed to 100 percent cost sharing in the coverage gap, a slight decline from 11 percent in 2007 (Figure 13-3, p. 324). Another 1.2 million non-LIS beneficiaries (4.2 percent) were in enhanced plans that provided some benefits in the coverage gap—usually limited to generic drugs. LIS enrollees, for whom the gap is eliminated, accounted for more than half of the enrollees with higher spending (4.6 million or 17 percent of all Part D enrollees). The share of Part D enrollees with spending high enough to reach Part D’s catastrophic coverage phase remained stable at 9 percent. Of these 2.4 million individuals, about 2 million received the LIS.

Fewer plans overall, but more premium-free plans for LIS beneficiaries in 2011

In 2011, beneficiaries have seen a reduction in the number of plan offerings, but they continue to have many choices of Part D plans. The reduction in plan offerings is primarily the result of recent regulations and guidance issued by CMS intended to differentiate more clearly between basic and enhanced benefit plans as well as to reduce the number of plans with low enrollment.⁹ In 2011, sponsors are offering 1,109 stand-alone PDPs, about 30 percent fewer than in 2010. There are 1,566 MA–PDs available, about 15 percent fewer than in 2010. These decreases have resulted from a decline in the number of local HMOs as well as a reduction by about one-half in the number of private fee-for-service plans offered, reflecting the change in policy that requires these plans to create provider networks. Still, Medicare beneficiaries continue to have 28 to 38 PDP options, along with many (sometimes dozens) MA–PD plans. The number of MA–PD plans available to a beneficiary varies by the county of residence.

In 2011, more PDPs will be available to LIS enrollees at no premium than in 2010 (Figure 13-4, p. 325). Two policies put in place by PPACA have allowed more plans to qualify as premium-free than would otherwise be the case: a new method for calculating the regional benchmarks and a *de minimis* policy.¹⁰ Under its *de minimis* policy, CMS is allowing plans to waive up to \$2 from their premiums to remain premium-free to LIS enrollees. A total of 332 PDPs have premiums at or below the LIS monthly premium subsidy amount for their region, compared with 307 in 2010.

**FIGURE
13-3****Share of Part D enrollees fully exposed to the coverage gap declined slightly in 2008**

Note: LIS (low-income subsidy). All Part D enrollees who receive the LIS do not face a coverage gap. A Part D enrollee reached the initial coverage limit when the total drug spending reached \$2,400 in 2007 and \$2,510 in 2008. An enrollee reached the annual out-of-pocket (OOP) threshold at \$3,850 of OOP spending in 2007 and \$4,050 of OOP spending in 2008. A small proportion of non-LIS enrollees who reached the catastrophic threshold may have had some gap coverage, but it is likely that most did not.

Source: Centers for Medicare & Medicaid Services 2008, Centers for Medicare & Medicaid Services 2010b.

Notable changes for 2011 in benefit design

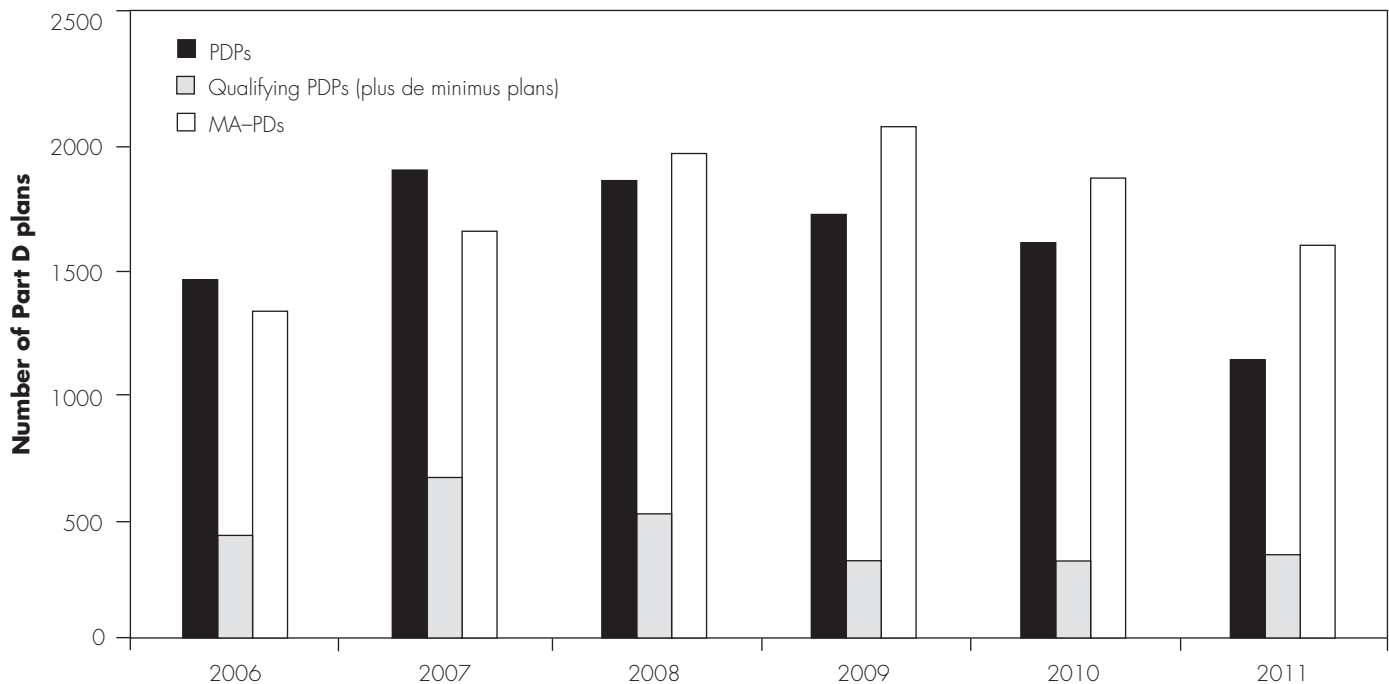
Beneficiaries who reexamined their options for the 2011 benefit year may have found some important changes in plan coverage.

Benefit designs

For the 2011 benefit year, despite the decrease in the number of plans offered, the structure of drug benefits for both stand-alone PDPs and MA-PDs held fairly steady. As in previous years, a smaller share of PDPs have no deductible (42 percent) compared with MA-PDs (87 percent). A majority of PDPs continue to charge a deductible in 2011, with most charging the defined standard amount (\$310).

In 2011, a larger percentage of PDPs provide some gap coverage (Figure 13-5, p. 326). In 2010, about 20

percent of PDPs (about 300 plans out of nearly 1,600 PDPs) included some gap coverage—usually some or all generic drugs but no brand-name drugs. For 2011, that share increased to 33 percent (365 plans out of about 1,100 PDPs). This increase is likely the result of a CMS guidance requiring plan sponsors to offer some coverage in the gap for brand-name drugs if a sponsor is offering two enhanced benefit plans in a given region (Centers for Medicare & Medicaid Services 2010a). By contrast, the share of MA-PDs with gap coverage held steady at just above 50 percent in 2011 (more than 800 of over 1,500 MA-PDs). The extent of coverage in the gap varies from plan to plan. For example, in 2010, 20 percent of PDPs provided coverage in the gap, but the share of generic drugs on the formulary that are covered ranged from 10 percent to 100 percent, with only 2 percent of plans covering any brand-name drugs (Hoadley et al. 2009).

**FIGURE
13-4****Fewer Part D plans overall, but more premium-free plans for LIS beneficiaries in 2011**

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Qualifying PDPs are plans for which LIS enrollees pay no premium because the plans' premiums are at or below a regional premium threshold. De minimis plans are plans that CMS permitted to retain their LIS enrollees because the plan premium was within a small variance from the regional LIS premium threshold.

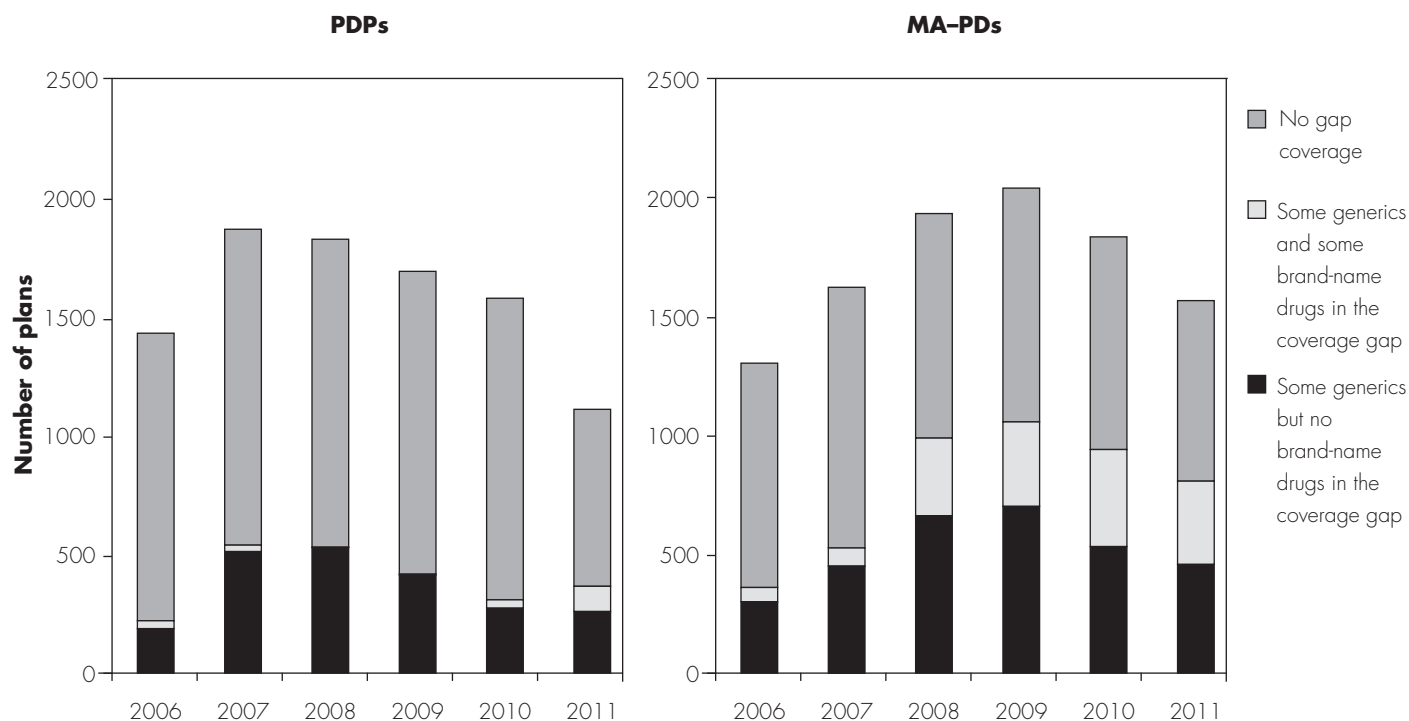
Source: CMS landscape files.

Plan formularies

In Part D, each plan sponsor operates one or more formularies—lists of the drugs the plans cover and the terms under which they cover them—to manage the cost and use of prescription drugs. When designing formularies, sponsors strike a balance between providing enrollees with access to medications and controlling growth in drug spending, which they accomplish by negotiating drug prices and dispensing fees with pharmacies and rebates with pharmaceutical manufacturers and by managing enrollees' utilization. Part D sponsors rely on clinicians—generally physicians and pharmacists who participate on a pharmacy and therapeutics committee—when deciding which drugs to list. Sponsors also select the cost-sharing tier for each listed drug and whether any utilization management tools apply, taking into account clinical and financial factors (such as how tier-placement decisions might affect sponsors' rebates from drug manufacturers). Making all

medications readily accessible at preferred levels of cost sharing can lead to Part D premiums that are high relative to a sponsor's competitors, whereas an overly restrictive formulary may keep a plan's premium competitive but may make the plan less attractive to potential enrollees because it covers a limited number of drugs.

Under contract with the Commission, researchers at NORC at the University of Chicago, Georgetown University, and Social and Scientific Systems analyzed Part D formulary data. CMS generally requires that plan formularies include at least two drugs in each therapeutic category and class unless only one drug is available. For this analysis, drugs are defined at the level of chemical entities—a broad grouping that encompasses all of a chemical's forms, strengths, and package sizes that combines brand-name and generic versions of specific chemicals (Medicare Payment Advisory Commission 2008).

**FIGURE
13-5****MA-PDs are more likely than PDPs to offer benefits in the coverage gap**

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]).

Source: MedPAC analysis of CMS landscape files.

The number of drugs that sponsors list on a formulary is one way to measure beneficiaries' access to prescription drugs under Part D. A plan's use of utilization management tools—such as its processes for nonformulary exceptions, prior authorization, quantity limits, and step therapy requirements—is another way to measure access.¹¹ For example, in some cases unlisted drugs are covered through the nonformulary exceptions process, which is relatively easy with some plan sponsors and more burdensome with others.

For the seven largest plans, which accounted for nearly half of the enrollment in stand-alone PDPs in 2010, the shares of all distinct chemical entities (drugs) listed on their formularies remained stable or saw modest changes between 2010 and 2011 (Table 13-2). Among the top seven PDPs, three plans—AARP MedicareRx Preferred, First Health Part D Premier, and CVS Caremark Value—saw a decrease in the share of drugs listed in 2011. However, the actual number of drugs listed on the formulary increased between 2010 and 2011 for First

Health Part D Premier, because the number of distinct chemical entities listed on CMS's formulary reference files also increased between 2010 and 2011.

The use of utilization management tools in Part D—including quantity limits, step therapy, and prior authorization—has grown in the past few years. Sponsors use such tools for drugs that are expensive; potentially risky; or subject to abuse, misuse, and experimental use. They also want to encourage the use of lower cost therapies. For 2011, the top seven stand-alone PDPs increased the share of drugs on plan formularies with some type of utilization management. The increase was generally modest, ranging from 1 percent to 4 percent for all but one plan. Among the top seven plans, two plans—Community CCRx Basic and CVS Caremark Value—have the highest share of drugs with utilization management in 2011. CVS Caremark Value (previously SilverScript Value) experienced the largest expansion in the share of drugs with utilization management between 2010 and 2011.

**TABLE
13-2****Formularies for stand-alone PDPs with highest 2010 enrollment**

Stand-alone PDPs with the highest 2010 enrollment	Enrollment, 2010 (in millions)	Percent of drugs on formulary**		Percent of drugs with any utilization management***	
		2010	2011	2010	2011
AARP MedicareRx Preferred	2.8	100%	94%	25%	27%
AARP MedicareRx Saver*	1.5	93	94	25	27
Humana PDP Enhanced	1.3	94	94	31	35
Community CCRx Basic	1.2	76	76	39	41
First Health Part D Premier	0.6	86	83	34	36
CVS Caremark Value	0.6	84	75	16	41
WellCare Classic	0.5	69	69	24	27

Note: PDP (prescription drug plan). Enrollment figures are based on September 2010 enrollment. The number of drugs on the formulary for 2010 is 1,107; for 2011, the number is 1,168.

*Plan not offered in 2011 (merged with AARP MedicareRx Preferred according to CMS's crosswalk file for 2011). Not all AARP MedicareRx Saver plan enrollees are automatically moved to the AARP MedicareRx Preferred plans.

**The denominator is the number of unique chemical entities based on CMS formulary reference files.

***Any utilization management includes the use of prior authorization, quantity limit, and step therapy requirements.

Source: NORC/Georgetown University/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS. MedPAC analysis of Part D enrollment data.

LIS enrollees and plan reassignments

Part D's LIS covers the cost of an enrollee's premium up to a specified amount. Each year, CMS sets an LIS premium threshold for each PDP region based on a weighted average of plans' premiums for basic benefits. As long as a plan's premium falls below the required benchmark, LIS beneficiaries pay no premium or a reduced premium if they remain in the plan.¹² However, LIS beneficiaries may be reassigned automatically on a random basis to a different PDP each year if their current plan's premium is too high. LIS enrollees may remain in their existing plan if they choose to pay the additional premium above the LIS benchmark; CMS refers to these individuals as "choosers."

Numbers of LIS reassigees

As of December 2010, we expect about 2.1 million LIS enrollees to be in plans that do not qualify as premium-free in 2011.¹³

- CMS estimates that it will have reassigned 600,000 LIS enrollees to different plans because their previous plan's premium no longer falls below the 2011 threshold (Hoadley et al. 2010). This number of reassigees is about half the number of reassignments for 2010. The new method for calculating the regional

benchmarks and the de minimis policy CMS has implemented for 2011 has reduced the number of reassignments (see section on plan availability, p. 323).

- Some LIS enrollees will have been reassigned to a qualifying plan offered by the same sponsoring organization. Because many sponsors use the same formulary for all their plans, these reassigned individuals are less likely to face significant changes.
- In 2010, about 1.7 million LIS members were enrolled in a plan they had selected (i.e., they did not remain in a randomly assigned plan) but that plan did not qualify as premium-free for 2010. Because of turnover in qualifying plans and the de minimis policy, some of their plans may qualify as premium-free in 2011.

LIS choosers

Some LIS enrollees choose to remain in their current plan rather than be reassigned to a new one. If at any time an LIS enrollee selects a plan different from the random assignment, CMS no longer reassigns the individual. By one preliminary estimate, about 2.5 million LIS enrollees fell into this "chooser" category for 2010 (Hill 2009). Some of these individuals were in plans that qualified as premium-free for 2010, were in MA-PDs,

Closer look at low-income subsidy choosers' choice of plans

In 2010, slightly more than 1.7 million beneficiaries were in stand-alone prescription drug plans that required them to pay some portion of the plan premiums out of pocket because the plan premiums exceeded the regional benchmarks. About two-thirds of enrollees paid \$10 or less per month in out-of-pocket premiums.

- Of the beneficiaries paying \$10 or less in monthly premiums, about a quarter paid \$2 or less. Had the de minimis policy been in effect, these beneficiaries would likely have had their premiums waived.

- Nearly 400,000 beneficiaries were enrolled in basic plans that required payment of additional premiums of between \$10 and \$45 per month, with a premium obligation that averaged \$14 per month.
- About 300,000 beneficiaries were enrolled in enhanced plans paying, on average, \$22 per month in out-of-pocket premiums, and some paid a premium as high as \$87 per month. ■

or participated in state pharmacy assistance programs. About 1.7 million LIS enrollees were in plans that did not qualify as premium-free; they received a letter from CMS notifying them that they could either switch to a qualifying plan or remain in the same plan and pay the difference between the plan's premium and the threshold amount that Medicare covers in the region. The premium amount such individuals need to pay varies across plans, ranging from 10 cents to more than \$80 per month. The most common amount is \$8 to \$10 per month (see text box).

Effects of switching plans

Beneficiaries who switch plans and the physicians and pharmacies who serve them could face transition issues as they change formularies. For example, an enrollee may need to negotiate transition supplies of drugs and try to navigate different coverage rules. The changes made by PPACA may lessen the burden on the LIS beneficiaries who are switched to different plans. Under the new law, LIS beneficiaries must be informed of the formulary differences and their right to request exceptions within 30 days of reassignment to a new plan. Part D enrollees who do not receive the LIS also face transition issues when they switch plans, and enrollees who remain in the same plan may still face some transition issues if their plan's formulary changes. In addition, plan sponsors are required to have a transition policy in place to ensure access to medications not on the new plan's formulary during the first 90 days.

Costs of Part D

To monitor Part D's costs, we examine aggregate program spending, per capita spending, trends in plans' bid amounts, trends in the prices at the pharmacy counter, enrollees' premiums, and plans' cost-sharing requirements. Spending for high-cost drugs and biologics is driving some components of Part D spending to grow more rapidly than others, and the Commission is concerned that the current competitive system may not be well-suited to deal with this rapid growth.

Aggregate program costs

Medicare pays sponsors three major types of subsidies on behalf of each enrollee in its plans:

- **Direct subsidy**—Medicare makes a monthly payment to plans set as a share of the national average bid for Part D basic benefits, adjusted for the risk of the individual enrollee.
- **Reinsurance**—Medicare subsidizes 80 percent of drug spending above an enrollee's annual OOP threshold. Reinsurance reduces the risk for Part D sponsors by providing greater federal subsidies for the highest cost enrollees.
- **Low-income subsidy**—Medicare pays projected LIS benefits to the plan to cover expected cost sharing and premiums for enrollees who are eligible for the LIS.

**TABLE
13-3****Medicare's reimbursement amounts for Part D on an incurred basis**

	Calendar year				
	2006	2007	2008	2009	2010*
In billions of dollars					
Direct subsidy	\$17.6	\$18.1	\$17.7	\$18.8	\$19.1
Reinsurance	6.0	8.1	9.4	10.3	11.3
Low-income subsidy	15.1	16.8	18.0	19.6	21.5
Retiree drug subsidy	3.8	3.9	3.8	3.8	4.0
Total	\$42.5	\$46.8	\$48.9	\$52.5	\$56.0
Annual percentage change					
Direct subsidy	N/A	2.7%	-2.3%	6.2%	2.0%
Reinsurance	N/A	33.7	17.2	9.5	9.4
Low-income subsidy	N/A	11.0	7.5	8.8	9.7
Retiree drug subsidy	N/A	1.4	-1.1	0.3	5.5
Total	N/A	9.9	4.7	7.3	6.6

Note: N/A (not applicable). The numbers reflect reconciliation amounts. Most enrollees paid premiums directly to Part D plans and those amounts are not included in this table. On a cash basis, the Board of Trustees estimates that premiums paid by enrollees totaled \$3.5 billion in 2006, \$4 billion in 2007, \$5 billion in 2008, \$6.1 billion in 2009, and \$6.6 billion in 2010. Totals may not sum due to rounding.

*Estimated.

Source: MedPAC based on Table IV.B.10 of the Medicare Board of Trustees' report for 2010.

The first two types of subsidies combined average 74.5 percent of the cost of basic Part D benefits for a non-LIS enrollee. Medicare also establishes symmetric risk corridors separately for each plan to limit plans' potential losses or gains by financing a portion of any higher-than-expected costs or by recouping a portion of higher-than-expected profits.

Low-income subsidy continues to be the largest share of Part D costs

Between 2006 and 2009, incurred reimbursements for Part D (including spending for the retiree drug subsidy) grew from \$42.5 billion to \$52.5 billion (Table 13-3). In 2009, the total consisted of \$18.8 billion in direct subsidy payments to plans, \$10.3 billion in payments for individual reinsurance, \$19.6 billion for the LIS, and \$3.8 billion in retiree drug subsidy (RDS) payments. Medicare's RDS subsidizes employers who provide primary drug coverage to their retirees that is at least as generous as Part D. CMS's Office of the Actuary estimated that Part D spending would total about \$56 billion in 2010 (Boards of Trustees 2010).

In 2009, spending for the LIS continued to be the largest component of Part D spending. Moreover, substantial portions of other categories of spending were made on behalf of LIS enrollees. Although only 36 percent of Part D enrollees receive the LIS, these recipients tend to use more medications than non-LIS enrollees. As a result, a disproportionate share of spending for the direct subsidy and for individual reinsurance also reflects benefits for LIS enrollees.¹⁴

Medicare payments for individual reinsurance grew considerably faster than other components of Part D spending in the first few years of the program. The main factor driving this growth in reinsurance spending was the trend in costs for drugs on plans' specialty tiers, which typically are higher priced products that have few, or no, therapeutic substitutes. For example, between 2007 and 2008, prices paid for drugs on specialty tiers grew by 18 percent compared with nearly 9 percent for all Part D drugs. Even after taking generic substitutions into account, the growth rate remained at 18 percent, indicating that there were almost no generic substitutions for these drugs. In contrast, prices remained stable for all Part D

**TABLE
13-4****Average gross per capita spending per month for Part D covered drugs, 2007–2008**

	2007–2008			
	2007	2008	Difference (in dollars)	Percent change
All Part D	\$212	\$221	\$9	4.2%
Plan type				
PDP	239	250	11	4.6
MA–PD	151	162	11	7.3
LIS status				
LIS	301	324	23	7.6
Non-LIS	156	159	3	1.9

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). Part D prescription drug event (PDE) records are classified into plan types based on the contract identification on each record. For purposes of classifying the PDE records by LIS status, monthly LIS eligibility information in Part D's denominator file was used. Estimates are sensitive to the method used to classify PDE records to each plan type and LIS status. Gross drug spending includes all payments to pharmacies, including payments by drug plans, Medicare's LIS, and beneficiary out of pocket.

Source: MedPAC analysis of Medicare Part D PDE data and denominator file from CMS.

drugs when generic substitution was taken into account (MaCurdy 2010).

Although Part D plan sponsors have an incentive to control drug spending, the degree to which they can control spending is weaker for single-source drugs and biologics. If one drug can be substituted for another, a plan can bargain with manufacturers that want their product placed on the plan's formulary in a favorable position (e.g., on a preferred tier rather than on a nonpreferred tier). But if a plan must cover an innovator drug that has no therapeutic substitute, which is the case for single-source drugs and most biologics, it has little negotiating power over the drug's price.

To control spending on these high-cost drugs, many plans have high cost sharing for drugs on specialty tiers and enrollees may not appeal the level of coinsurance charged. For 2010, in plans with specialty tiers, enrollees typically faced 30 percent coinsurance for drugs listed on that tier.¹⁵ Beneficiaries who regularly use drugs on a specialty tier are likely to reach the coverage gap in a short time and face 100 percent coinsurance until their drug spending reaches the catastrophic limit. If beneficiaries are able to continue paying for the drug during the coverage gap, they will receive catastrophic coverage for several months of the year, while the plan's liability is limited to 15 percent of all covered drug spending for the rest of the year. LIS beneficiaries use a disproportionate share of high-cost

drugs and biologics, and most of the cost sharing is picked up by Part D's LIS.

Per capita spending

Under the Part D program, payments to plans are determined based on the average of bids plan sponsors submit to CMS each year. The bids are intended to reflect the expected costs for a Medicare beneficiary of average health; CMS adjusts payments to plans based on the actual health status of the plans' enrollees.

In 2007 and 2008—the latest years available for prescription drug event data—average per capita spending for drugs covered in Part D for MA–PD enrollees was lower than that for stand-alone PDP enrollees, and average per capita spending for LIS enrollees was about double that for non-LIS enrollees (Table 13-4). Per capita drug spending also varied across PDP regions, even after adjustments were made for differences in demographic characteristics, health status, and prices (see text box).

Between 2007 and 2008, average per capita spending per month grew by 4.2 percent (Table 13-4), but the growth rate varied widely across groups of beneficiaries. Most notably, the growth in per capita drug spending for non-LIS enrollees was significantly lower (1.9 percent) than that for LIS enrollees (7.6 percent). Although the growth in per capita drug spending among MA–PD enrollees

Regional variation in prescription drug use

Regional variation in Medicare spending continues to receive considerable attention. Studies, including work by the Commission, have consistently found substantial variation across regions, even after adjustments are made for differences in demographic characteristics, health status, and prices (Medicare Payment Advisory Commission 2009, Medicare Payment Advisory Commission 2011).

Our previous work found that average per capita spending for drugs covered under Part D varies widely across prescription drug plan regions. For example, in 2008, average per capita spending nationally was \$2,545, with the lowest spending region 22 percent below the average and the highest spending region 34 percent above the average. Although adjusting for regional differences in demographic characteristics, health status, and prices reduces the variation in spending, average per capita drug spending still varied considerably, ranging from 12 percent below the national average to 23 percent above the national average (Medicare Payment Advisory Commission 2010a).

In our most recent work on regional variation, we found that beneficiaries' drug use (i.e., drug spending adjusted for variations in prices, demographic characteristics, and health status) varied across regions, although the variation was considerably less than unadjusted drug spending (Medicare Payment Advisory Commission 2011).

For example, drug use for beneficiaries living in the area at the 90th percentile was 21 percent higher than for beneficiaries living in the area at the 10th percentile, while the comparable figure for drug spending was 39 percent. Drug use in the highest use area is about 1.7 times that in the lowest use area (Table 13-5).

These findings may have different policy implications than for Part A and Part B services that are paid under the fee-for-service system, since under Part D competitive bidding by plan sponsors determines what Medicare ultimately pays for the Part D benefit as well as what enrollees pay in plan premiums. ■

**TABLE
13-5**

Drug use has less regional variation than drug spending, but differences remain

Measure of variation	Drug spending	Drug use
Ratio of 90th to 10th percentile	1.39	1.21
Ratio of maximum to minimum	2.14	1.68
Average distance from the mean (PMPM)	\$20	\$12

Note: PMPM (per member per month). Drug spending is average gross drug spending among Part D enrollees. Drug use is per capita drug use among Part D enrollees in each area. Areas are defined as metropolitan statistical areas for urban counties and rest-of-state nonmetropolitan areas for nonurban counties.

Source: MedPAC analysis of 2007 and 2008 beneficiary-level Medicare spending from prescription drug event data.

was greater than that for stand-alone PDP enrollees (7.3 percent compared with 4.6 percent), growth in terms of the dollar increase was the same for both groups (\$11).

National average bid

Between 2010 and 2011, national average costs for basic Part D benefits are projected to grow at slightly more than 1 percent (Table 13-6, p. 332). During this period, the monthly payment to sponsors (i.e., the direct subsidy component) of Part D benefit spending is projected to decrease by about 3 percent, while the reinsurance component is expected to grow by about

8 percent.¹⁶ Although the growth in the reinsurance component is considerably lower than the 20 percent growth seen between 2008 and 2009, the Commission has been concerned about the high rate of growth in these payments, reflecting higher estimates for the cost of Part D's catastrophic coverage.¹⁷ We will continue to watch this issue with interest, encouraging CMS to do the same.

Part D drug prices

Most plan sponsors do not negotiate drug prices directly with pharmaceutical manufacturers. Instead, sponsors engage in two separate negotiations:

**TABLE
13-6****National average bid and components of average prospective monthly payments per enrollee for basic coverage**

	2006 ^a	2007 ^b	2008 ^c	2009 ^d	2010 ^d	2011 ^d
Amounts in dollars						
National average monthly bid						
Base beneficiary premium	\$32.20	\$27.35	\$27.93	\$30.36	\$31.94	\$32.34
Monthly payment to sponsors	60.10	53.08	52.59	53.97	56.39	54.71
Subtotal	92.30	80.43	80.52	84.33	88.33	87.05
Expected individual reinsurance	<u>33.98</u>	<u>26.82</u>	<u>29.01</u>	<u>34.73</u>	<u>36.92</u>	<u>39.77</u>
Total average benefit cost	126.28	107.25	109.53	119.06	125.25	126.82
Annual percent change						
National average monthly bid						
Base beneficiary premium	N/A	-15%	2%	9%	5%	1%
Monthly payment to sponsors	N/A	-12	-1	3	4	-3
Subtotal	N/A	-13	0	5	5	-1
Expected individual reinsurance	N/A	-21	8	20	6	8
Total average benefit cost	N/A	-15	2	9	5	1

Note: These amounts reflect averages based on bids to provide basic Part D benefits; they do not net out subsequent reconciliation amounts with CMS. They were calculated from bids by plans to provide the defined standard benefit or actuarially equivalent basic benefits as well as the portion of enhanced Part D coverage attributable to basic benefits. Enrollees in plans with enhanced coverage must pay the full price of benefits that supplement basic coverage. The combination of monthly payments to plans and expected payments for individual reinsurance make up 74.5 percent of total average monthly benefit costs.

a. Since Part D began in 2006, Medicare law directed CMS to weight the bids of stand-alone drug plans equally (with an aggregate weight representing enrollment in traditional Medicare) and weight bids from Medicare Advantage (MA) drug plans by their prior-year MA enrollment.

b. CMS used its general demonstration authority to calculate these values using 20 percent enrollment weighting and 80 percent weighting as in the 2006 approach.

c. CMS used its general demonstration authority to calculate these values using 60 percent enrollment weighting and 40 percent weighting as in the 2006 approach.

d. Bids are fully weighted by prior-year enrollment as called for by law.

Source: MedPAC based on CMS releases of Part D national average monthly bid amounts and base beneficiary premiums for 2006 through 2011 as well as other data provided by CMS.

- The first involves pharmacies or a network of pharmacies over the prices the plan will pay the pharmacy for drug ingredient costs and dispensing fees.
- The second involves the terms under which manufacturers pay retrospective rebates.

Plan sponsors tend to use rebate revenues to offset plans' benefit spending (reducing plan premiums) rather than lowering the price of prescriptions at the pharmacy counter, so that drug prices measured in this section are not affected by the outcomes of the second negotiations.

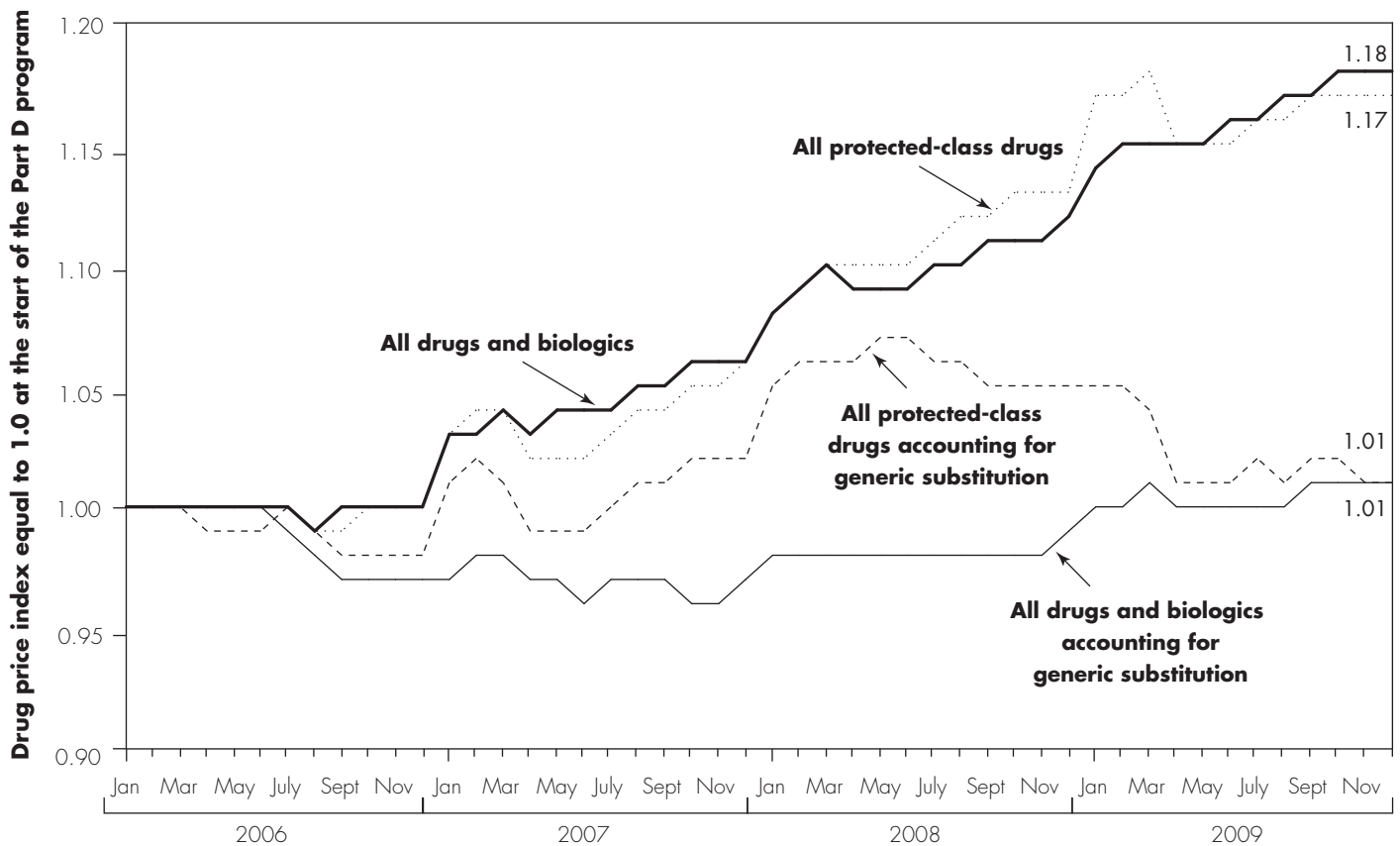
Part D plan sponsors have had mixed success at influencing drug prices. They have been quite successful at encouraging enrollees to use generic alternatives when available (Office of Inspector General 2007). Plan

sponsors regularly steer enrollees and negotiate rebates from manufacturers for brand-name drugs that have therapeutic alternatives. But sponsors have had less success negotiating rebates for unique drug and biologic products.

To track drug prices, the Commission contracted with researchers at Acumen, LLC, to construct a series of volume-weighted price indexes (Figure 13-6). The indexes do not reflect retrospective rebates from manufacturers but do reflect the prices sponsors and beneficiaries paid to pharmacies at the point of sale (including ingredient costs and dispensing fees). Measured by individual national drug codes (NDCs), Part D drug prices rose by an average of 18 percent cumulatively between January 2006 and December 2009.¹⁸ At the same time, Part D sponsors have had success encouraging enrollees to switch from brand-

**FIGURE
13-6**

**Availability of generics, rather than protected status,
key to slower price growth under Part D**



Note: Chain-weighted Fisher price indexes.

Source: Acumen, LLC, analysis for MedPAC.

name drugs to generic substitutes, particularly during the program's first two years. As measured by a price index that takes this substitution into account, Part D prices grew cumulatively by 1 percent between January 2006 and December 2009.¹⁹

For most drug classes, CMS requires plan formularies to cover at least two drugs in every therapeutic class and key drug type that are not therapeutically equivalent, unless there is only one drug approved for that class. This policy protects beneficiaries who need a drug that is the only one available to treat a certain condition and allows competition in classes with multiple products. For six drug classes, CMS requires Part D plans to cover "all or substantially all" drugs in the class. Those classes are antineoplastics, antidepressants, antipsychotics, antiretrovirals, anticonvulsants, and immunosuppressants

used by transplant patients. Although plans can still charge higher cost sharing for them, such as by placing them on tiers for nonpreferred brands, plans may have limited ability to steer utilization for these classes of drugs.

As measured by individual NDCs, prices for drugs in the six classes showed a trend similar to that for all Part D drugs, rising by a cumulative 17 percent over the four-year period (Figure 13-6). However, the observed 17 percent growth is influenced heavily by two classes of drugs: antidepressant medications, which account for about half of the volume in the six classes and had many generics on the market during this period; and anticonvulsants, which account for more than a quarter of the volume and also had generic alternatives available during the same period.

Our price index for the individual NDCs of antidepressant and anticonvulsant drugs fell by nearly 4 percent and 10

percent, respectively, during the four-year period (data not shown). Other classes are made up almost entirely of brand-name drugs, and for these products, prices grew rapidly, ranging from a little more than 20 percent for antiretrovirals to 46 percent for antineoplastics.

When protected-class drugs were grouped to take generic substitution into account, their prices grew by a cumulative 1 percent over the four-year period. Thus, despite the drugs' protected status, plan sponsors appeared to have had success at moving enrollees toward generics for these drugs, when generic substitutes are available. However, it is possible that the drugs' protected status may keep plan sponsors from negotiating rebates from manufacturers in classes in which one brand-name drug can be a therapeutic substitute for another brand-name drug. We lack rebate information to test this hypothesis.

Average Part D premiums

In 2011, the base beneficiary premium will be \$32.34, a slight increase from \$31.94 in 2010. Since premiums vary widely across plans, the actual average monthly premium will depend on beneficiaries' choice of plans. For the basic portion of the benefit (the portion that does not include premiums for enhanced, or supplemental, benefits), CMS estimates the actual average monthly premium at \$30 in 2011, a \$1 increase over the average in 2010.²⁰ The estimate reflects CMS's expectation that some Part D enrollees will switch to plans with lower premiums.

In the past, the Commission has calculated the expected average Part D premiums as well as the expected change in premiums for the coming year using the current year enrollment. These estimates would not match the actual average premiums paid since they assume that all enrollees remain in their current plans; however, the estimates provided some sense of the level of premiums beneficiaries will pay.

We did not calculate the expected average premiums for 2011, as they would be sensitive to the assumptions we make about beneficiary switching.²¹ As mentioned above, many plans will be discontinued or consolidated in 2011. The change is primarily the result of recent CMS regulations and guidance intended to reduce the number of plan offerings. In the past, a relatively small share (around 6 percent) of enrollees switched plans in any given year. The large reduction in the number of plan offerings will likely result in more beneficiaries switching plans and in greater uncertainty about beneficiaries' choice of plans for the coming year.

As a result of changes made in PPACA, higher income beneficiaries will be subject to a reduced premium subsidy beginning in 2011. Similar to the income-related premium for Part B, the reduced subsidy applies to individuals with an annual adjusted gross income (AGI) greater than \$85,000 and for couples with AGI greater than \$170,000. As of December 2010, CMS expects that roughly 1 million beneficiaries will pay the surcharge in 2011.

Plans' cost-sharing requirements

Cost-sharing requirements have generally been rising over the past few years (Medicare Payment Advisory Commission 2010b). In 2011, cost-sharing requirements for the top seven stand-alone PDPs based on enrollment in 2010 generally rose, but there are some notable reductions (Table 13-7). For example, WellCare Classic reduced its cost sharing for generic drugs from \$4 per 30-day prescription to \$0, and Humana Enhanced reduced the cost sharing for both preferred brand-name drugs and nonpreferred brand-name drugs by \$6 and \$2, respectively. But there are some significant increases as well. Beneficiaries enrolled in the CVS Caremark Value plan face cost sharing of \$40 per 30-day prescription for a brand-name drug on the preferred tier compared with \$22 in 2010.

For 2011, coinsurance for drugs on a specialty tier remains flat for most of the top seven plans, with the exception of AARP MedicareRx Preferred enrollees who were enrolled in the AARP MedicareRx Saver plan in 2010.²² For these enrollees, coinsurance for drugs on specialty tiers will increase to 33 percent from 25 percent in 2010. Another notable change is the addition of a specialty tier with 25 percent coinsurance by Community CCRx Basic in 2011. In 2010, the plan formulary had a three-tier structure with one tier for generic drugs and two tiers, preferred and nonpreferred, for brand-name drugs. In 2010, the cost-sharing amounts for the brand-name drugs were 25 percent and 58 percent for preferred and nonpreferred brand-name drugs, respectively.

From an enrollee's perspective, cost-sharing requirements for specialty-tier drugs can be high until the enrollee reaches Part D's catastrophic spending limit. In addition, under CMS's regulations, enrollees may not appeal specialty-tier cost sharing as they can for other drugs, such as those on tiers for nonpreferred brands. Because drugs on specialty tiers are often used to treat serious chronic illnesses such as rheumatoid arthritis and multiple sclerosis, patients who need these drugs can

**TABLE
13-7****Cost-sharing amounts for stand-alone PDPs with highest 2010 enrollment**

Stand-alone PDPs with the highest 2010 enrollment	Enrollment, 2010 (in millions)	Tier							
		Generic		Preferred brand		Nonpreferred brand		Specialty	
		2010	2011	2010	2011	2010	2011	2010	2011
AARP MedicareRx Preferred	2.8	\$7	\$7	\$42	\$45	\$74.75	\$79	33%	33%
AARP MedicareRx Saver*	1.5	6	7	\$25	\$45	\$81.38	\$79	25	33
Humana PDP Enhanced	1.3	7	7	\$45	\$39	\$75	\$73	33	33
Community CCRx Basic	1.2	0	2	25%	31%	58%	60%	N/A	25
First Health Part D Premier	0.6	7	8	11%	17%	43%	36%	29	29
CVS Caremark Value	0.6	8	5	\$21.75	\$39.75	\$95	\$95	25	25
WellCare Classic	0.5	4	0	\$35	\$42	\$73	\$92	25	25

Note: PDP (prescription drug plan), N/A (not available). Enrollment figures are based on September 2010 enrollment. In cases in which plans vary cost-sharing amounts across regions, we report unweighted median cost-sharing amounts.

*Plan not offered in 2011 (merged with AARP MedicareRx Preferred according to CMS's crosswalk file for 2011). Not all AARP MedicareRx Saver plan enrollees are automatically moved to the AARP MedicareRx Preferred plans.

Source: NORC/Georgetown University/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

face relatively high cost sharing for medications on top of significant OOP costs for their medical care. From a sponsor's perspective, high-cost drugs may be used more widely than the evidence of their effectiveness supports, and higher coinsurance may temper their use. Moreover, if most of a sponsor's competitors use specialty tiers, it may be important to use a specialty tier to limit the risk of attracting sicker enrollees who are taking very expensive drugs.

Measuring plan performance in Part D

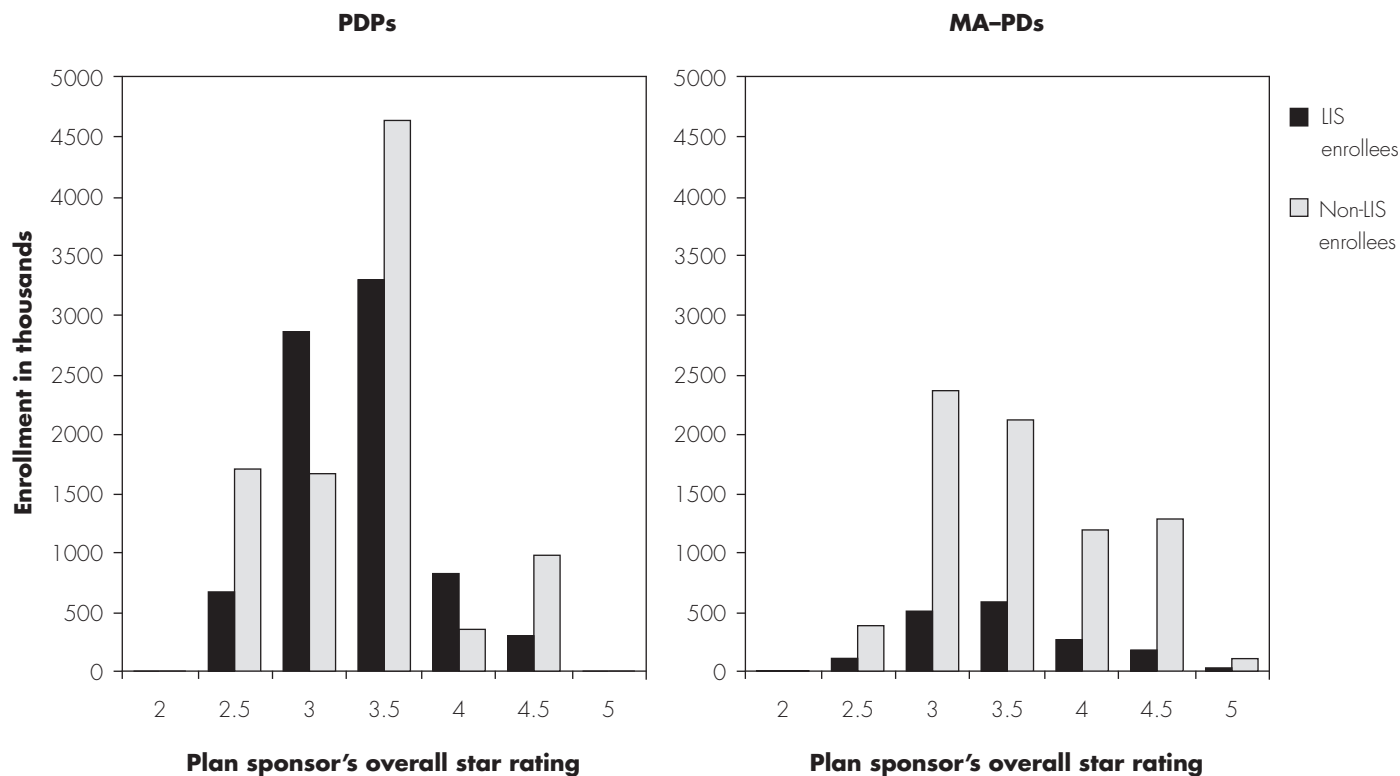
CMS collects quality and performance data for Part D plans to monitor sponsors' operations and help beneficiaries choose among plans. CMS relies on several sources for these data—the Consumer Assessment of Health Providers and Systems survey, agency monitoring of plans, and data furnished by sponsors. CMS is also beginning to use claims information as another source for building quality measures. In 2010, 19 metrics were grouped into four domains:

- drug plan customer service (seven measures);
- member complaints, members who chose to leave, and audit findings (four measures);

- member experience with drug plans (three measures); and
- drug pricing information and patient safety (five measures).

Two of the measures in the last domain relate to patient safety.²³ The first captures elderly members' use of drugs that have a high risk of side effects when there may be safer drug choices. The second is a measure of optimal treatment for diabetes patients. Other patient safety measures are under review by organizations that focus on quality measurement, such as the Pharmacy Quality Alliance, and CMS may adopt these measures once they have been validated and endorsed. None of CMS's currently available measures captures whether enrollees received their prescribed drug or an alternative therapy without undue delay.

CMS aggregates individual scores for each of the 19 measures on the Plan Finder into a 5-star system based on adjusted percentile rankings of sponsors; 5 stars means excellent performance and 1 star reflects poor performance. CMS presents star ratings that combine individual scores in each domain as well as a summary ranking that represents overall performance. The distribution of stand-alone PDP sponsor ratings ranges from 2.5 stars to 4.5 stars, while MA–PD sponsors range

**FIGURE
13-7****LIS and non-LIS enrollment by plan sponsors' star ratings, 2009**

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Star ratings shown reflect a composite of 19 performance measures, where one star means "poor" and five stars means "excellent" performance. Sponsor scores are available for the 2010 version of the Medicare Prescription Drug Plan Finder tool available at www.medicare.gov.

Source: MedPAC analysis of CMS Part D performance and enrollment data.

from 2.0 stars to 5.0 stars. Generally, LIS enrollees do not tend to be in plans run by sponsors with star ratings that differ systematically from plans that enroll more non-LIS beneficiaries (Figure 13-7).

In 2008, the Commission convened an expert panel on Part D performance ratings that highlighted the importance of developing performance metrics that measure cost, access, quality, and customer service. The measures now include some quality measures, but additional measures of patient safety and appropriate medication use could provide better information on quality.

Policy issues

Evidence on Part D to date indicates that beneficiaries enrolled in Part D are generally satisfied with the Part D

program and continue to have good access to prescription drugs. However, several factors related to Part D spending deserve closer attention:

- **Voluntary plan switching**—Year-to-year changes in enrollment are part of the design of Part D: Plans that are able to manage drug spending and bid more competitively are supposed to be rewarded with higher enrollment than plans that do not. To date, only about 6 percent of Part D enrollees have switched plans voluntarily each year. While general satisfaction with their plans may contribute to a low rate of switching among beneficiaries, there may also be obstacles that prevent some beneficiaries from switching to another plan. If beneficiaries are unwilling to switch, plans have less incentive to keep premiums low. Although CMS provides tools like the web-based Plan Finder to help beneficiaries compare plan options, choosing among options that differ on multiple dimensions can

be difficult and time-consuming. Providing measures of how well plans' transition policies work for new enrollees may allow more beneficiaries to switch to another plan while avoiding transition issues.

- ***Performance measures***—CMS makes available selected performance measures and overall plan ratings based on those measures on www.medicare.gov to help beneficiaries evaluate their plan options during annual open enrollment season. Although there are two metrics related to patient safety, most metrics relate to the quality of customer service. It is not clear how helpful the overall ratings have been to beneficiaries evaluating their options. Including additional measures of clinical quality may provide information that will help beneficiaries evaluate plan options in a more meaningful way and may encourage more enrollees to switch plans.
- ***Spending for high-cost drugs***—The Commission has been monitoring the growth in spending for high-cost drugs and biologics that have few, or no, therapeutic substitutes. Enrollees who use these products enter the catastrophic phase of the benefit very quickly. The rapid growth in prices paid for these products has led to fast growth in program spending for Part D's individual reinsurance. Although plan sponsors have an incentive to control drug spending, the degree to which they can control spending is weaker for single-source drugs and biologics. Since LIS beneficiaries use a disproportionate share of the high-cost drugs and biologics, most of the cost sharing is picked up by Part D's LIS, which has become the single largest component of Part D program spending. Because of the difficulty plan sponsors face in negotiating discounts and rebates for high-cost drugs and biologics, the current structure of the program may not be well-suited to these types of products. ■

Endnotes

- 1 In 2020, the OOP threshold reverts to the level it would have reached had annual increases been calculated at the average change in per capita drug spending.
- 2 According to a CMS announcement, all manufacturers of brand-name drugs, except for some that repackage or relabel drugs, signed the agreement to provide the 50 percent discount.
- 3 The amount of total covered drug spending at which a beneficiary meets the annual OOP threshold depends on the mix of brand-name and generic drugs that the individual fills during the coverage gap. The 2011 amount of total drug expenses at the annual OOP threshold of \$6,447.50 is for an individual with no other sources of supplemental coverage filling only brand-name drugs during the coverage gap.
- 4 For prescriptions filled during the coverage gap, the coinsurance percentage under the defined standard benefit applies only to the negotiated price of the drug, excluding dispensing fees, which differs from how the coinsurance applies during the initial benefit phase, when the coinsurance percentage applies to the gross cost of the drug, including dispensing fees.
- 5 If an employer agrees to provide primary drug coverage to its retirees with an average benefit value that is equal to or greater than Part D (called creditable coverage), Medicare provides the employer with a tax-free subsidy for 28 percent of each eligible individual's drug costs that fall within a specified range of spending. Under PPACA, employers still receive the retiree drug subsidy on a tax-free basis, but, beginning in 2013, they will no longer be able to deduct prescription drug expenses for which they receive the subsidy as a cost of doing business.
- 6 Medicare allows insurers to offer two types of plans that have the same average benefit value as the defined standard benefit. The first type, which CMS calls actuarially equivalent, uses the same deductible as the defined standard benefit but has different cost sharing during the plan's initial coverage phase. The second type, called basic alternative, allows insurers to use a lower deductible than the defined standard benefit, different cost sharing, and a modified initial coverage limit. Because they have the same average benefit value as the defined standard benefit, in this chapter we refer to both types as actuarially equivalent benefits.
- 7 Sponsors can enhance benefits in other ways as well—for example, covering drugs not allowed under basic Part D benefits, such as weight-loss medications and over-the-counter products. In the first few years of the Part D program, a handful of PDP sponsors offered products that covered some brand-name and generic drugs in the coverage gap. However, those plans attracted beneficiaries with relatively high spending on drugs and the plans experienced financial losses. In the following years, nearly all affected sponsors withdrew those products from the market.
- 8 Under the Part C payment system, which is used to pay Medicare Advantage plans, 75 percent of the difference between the plan's benchmark payment and its bid for providing Part A and Part B services is referred to as Part C rebate dollars. The rebate dollars can be used to supplement benefits or lower premiums for services provided under Part C or Part D.
- 9 CMS is allowing sponsors to offer only one basic plan and up to two enhanced plans in any given region, with a requirement that the plans have "meaningful differences"—defined as a difference of \$22 or more in a beneficiary's expected monthly OOP cost for a common market basket of drugs between basic and enhanced plans. In addition, CMS discourages plans with fewer than 1,000 enrollees.
- 10 There has been a concern that, in areas where MA-PDs hold large shares of enrollment, the ability of MA-PDs to reduce their drug premiums with "rebate dollars" from the Medicare Advantage payment system would lead to lower regional thresholds and fewer PDPs with premiums below those thresholds. By excluding "rebate dollars" from calculation of the regional thresholds, the new calculation method would result in higher thresholds, particularly in areas with large shares of enrollment in MA-PDs.
- 11 Prior authorization refers to requirements for preapproval from a plan before coverage. Quantity limits refer to a plan limiting the number of doses of a particular drug covered in a given time period. Under step therapy, plans require the enrollee to try specified drugs before moving to other drugs.
- 12 Most LIS enrollees pay no premiums, but those with incomes between 135 percent and 150 percent of the federal poverty level pay a portion of their plan's premium.
- 13 This estimate is from the Commission's analysis of CMS enrollment and crosswalk files.
- 14 Direct subsidy payments for LIS enrollees are risk-adjusted to reflect their higher average drug spending.
- 15 For 2010, the median coinsurance drugs listed on specialty tiers was 30 percent for PDP enrollees and 33 percent for MA-PD enrollees.

- 16 The growth in the reinsurance component of the bid between 2010 and 2011 reflects, in part, the expectation that the changes made to the Part D benefit under PPACA to reduce cost sharing in the coverage gap will result in higher reinsurance costs in 2011.
- 17 The growth in the reinsurance component of the bid between 2008 and 2009 (20 percent) reflects plans' expectations about the amount of spending that will fall into the catastrophic range of spending for a beneficiary with average health. The incurred spending for reinsurance grew by 9.5 percent between 2008 and 2009 (Table 13-3). The growth rates differ because the incurred spending reflects aggregate payments made to plans after adjusting for the health status of enrollees in each plan and are based on actual utilization (rather than plans' expectations).
- 18 By individual NDC, we mean prices across the exact same code that identifies the drug's labeler, drug, dosage form, strength, and package size. Because each specific drug often is available in different dosages, strengths, and package sizes, the same drug typically has many NDCs.
- 19 For this index, Acumen grouped NDCs that are pharmaceutically identical, aggregating prices across trade drug names, manufacturers, and package sizes. As a result, brand-name drugs are grouped with their generics if they exist, and the median price more closely reflects the degree to which market share has moved between the two.
- 20 CMS reported its estimate of the average monthly Part D premium for 2011 (\$30) in a public conference call.
- 21 In September 2010, Avalere Health estimated that the premiums for the top 10 stand-alone PDPs would increase 10 percent, on average, in 2011. They later released a revised estimate that the premium increase would be 0.2 percent for the top 10 stand-alone PDPs. A separate estimate by researchers at Georgetown University and NORC expects premiums for PDPs to be 10 percent higher if all enrollees remain in their current plan.
- 22 The AARP MedicareRx Saver plan merged with the AARP MedicareRx Preferred plan in 2011 and therefore is no longer offered in 2011.
- 23 Other Part D performance measures are available but are not on the Plan Finder. For example, each sponsor's generic dispensing rate is shown on the agency's website. Similarly, CMS posts other measures to its site that are still under development, are duplicative, or are limited by a small sample size. Among them, two are related to patient safety: a measure of drug-drug interactions and another of diabetes medication dosing. At CMS's Patient Safety Analysis website, which is available only to CMS and plan sponsors, sponsors can track their patient safety measures monthly and obtain more detailed information.

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